DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1175 (10/01)

STATE OF WISCONSIN
HFS 106.13, 105.17(2)(b)(3), 107.112 (3)(c)

WISCONSIN MEDICAID
RECIPIENT REQUEST FOR VARIANCE OF
60-DAY SUPERVISORY VISIT REQUIREMENT

Medicaid Recipient's Name	Recipient's Medicaid ID Number

Before completing this form, read the statement on the reverse side.

I, _____ (Medicaid recipient or guardian of recipient), request that Wisconsin Medicaid not require a nurse to visit my home every 60 days. I have read (or have had read to me) the attached "Medical Professional Statement in Support of Request for Variance of 60-Day Supervisory Visit Requirement" form and the updated plan of care. I agree with the period between registered nurse (RN) visits indicated in the updated plan of care. I understand that:

1. I have the right to RN visits at least once every 60 days if I want them.
2. I may contact my physician, RN, or personal care agency if I want more frequent RN visits.
3. I will contact my RN, personal care agency, or physician if I have problems with my personal care worker.
4. I am expected to notify my Medicaid provider of any changes in my medical condition.
5. The nurse and my physician have the required contact plan in place that provides for both routine and emergency contact with them.
6. I may increase the frequency of visits at any time.
7. My physician, RN, personal care agency, or Wisconsin Medicaid may increase the frequency of visits at any time with or without my agreement.

SIGNATURE — Medicaid Recipient or Guardian	Date Signed
Medicaid Billing Provider's Name	Provider's Telephone Number
Medicaid Billing Provider's Address (Street, City, Zip Code)	

Reset Form

Wisconsin Medicaid requires specific information to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02 [4], Wis. Admin. Code).

Under s. 49.45 (4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for these services.

This form is authorized under HFS 106.13, Wis. Admin. Code. Completion of this form is mandatory to obtain a variance from Wisconsin Medicaid's 60-day registered nurse (RN) supervisory visit requirement under s. HFS 105.17(2)(b)(3) and 107.112(3)(c), Wis. Admin. Code, such that visits may be made less often than every 60 days. The variance may be granted only to personal care-only agencies, not home health agencies.